COVENTRY
Health Care of Delaware, Inc.

GROUP NAME _____ GROUP # _____ Benefit Plan: HMO ☐ POS ☐ (Check One)

Coventry Health Care of Delaware, Inc.
(800) 833-7423

Group Enrollment Form

1. Please print or type all necessary information. DO NOT WRITE IN SHADED AREAS.
2. Complete all items requested.
3. NEW MEMBERS: Complete all items in Sections B, C, and D.
4. CURRENT MEMBERS: Check all items you wish to change in Section A. Complete Section B with your name and social security number. Fill in Sections C and D with updated information.
5. ALL MEMBERS: Complete pink copy & retain as Temporary I.D. Card for use until permanent card arrives.

Office Use Only

Group No.	Subscriber No.:	Effective Date:
Pharmacy Code:	**Benefit Code:**	

Section A

Check all that apply:
- _____ Name Change
- _____ Address Change
- _____ Telephone Change
- _____ Change Primary Care Physician
- _____ Pharmacy Change
- _____ Card Correction

Add Dependent(s):_____(date)
- _____ Marriage
- _____ Newborn
- _____ Adoption
- _____ Legal Guardianship
- _____ Other

Cancel Dependent(s) only____(date)
- _____ Marriage
- _____ Divorce
- _____ Age Limit
- _____ Other

Cancel All Coverage_____(date)
- _____ Terminate Employment
- _____ Voluntary Withdrawal
- _____ Leave/Layoff
- _____ Out of Service Area Move
- _____ Other

Continuation_____ (date)
Conversion_____ (date)

Cobra_____(date)
- _____ Death
- _____ Termination
- _____ Reduction in work hours
- _____ Divorce/Separation
- _____ Medicare Eligible
- _____ Loss of Dependent Eligibility
- _____ Retirement

Reinstatement_____(date)
- _____ Return from layoff
- _____ Return from leave
- _____ Rehire
- _____ Disenrollment error
- _____ Other

Section B

Last Name	First Name	Middle Initial	Social Security #

Section C

Address (Number, Street, Apartment)	City	State	ZIP Code	Home Tel. No.
Date of Hire	**Employer Name, Location**			**Work Tel. No.**

Section D

Please select a Primary Care Physician for you and your dependents before submitting this application.

Last Name, First Name, MI.	Full Time Student Y/N	Member No.	Birthdate Mo/Day/Yr	Sex M/F	Social Security No.	Other Health Insurance Including Medicare	CHC Subscriber No.	Primary Care Physician	Current Patient Y/N	Primary Care Physician Provider
Subscriber		01								
Spouse		02								
Child										
Child										
Child										
Child										
Child										

I am applying for covered services for which I and my family dependents are eligible under the CHC Group Membership Agreement with my employer. I authorize my employer to deduct from my earnings the amount required.

All information on this form is true and correct to the best of my knowledge.

I agree on behalf of myself and my family dependents to abide by the terms of the agreement describing my Coverage. I authorize any provider who provides services to me or my family dependents to release to CHC and its participating providers any information or medical records relating to those services. I will complete and sign any documents necessary for the CHC to assume my or my family dependent's legal rights to collect from a third party any costs the CHC incurred.

I also understand that the CHC Membership Agreement contain a provision which obligates me to follow a complaint procedure or any claim or disputes regarding Coverage.

_____ / _____
Employee Signature Date

_____ / _____
Employer Representative Signature Date